DEPARTMENT OF HEALTH & SOCIAL SERVICES

PROPOSED CHANGES TO REGULATIONS

Medicaid Coverage, Medicaid Payment Rates, Medicaid Program (Individualized Supports Waiver, Community First Choice, Long Term Services & Supports Targeted Case Management)

- **7 AAC 127. Medicaid Coverage; Community First Choice. → *NEW PROPOSED REGULATIONS***
- **7 AAC 128. Medicaid Coverage; Long Term Services & Supports Targeted Case Management. → *NEW PROPOSED REGULATIONS***
- **7 AAC 130. Medicaid Coverage; Home & Community-Based Waiver Services.**
- **7 AAC 145. Medicaid Payment Rates.**
- **7 AAC 160. Medicaid Program; General Provisions.**

♦

PUBLIC REVIEW DRAFT
October 17, 2017

COMMENT PERIOD ENDS: November 27, 2017
Please see the public notice for details about how to comment on these proposed changes.

Notes to reader:

1. Except as discussed in note 2, new text that amends an existing regulation is **bolded and underlined**.

2. If the lead-in line above the text of each section of the regulations states that a new section, subsection, paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.

3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is to be deleted.

4. When the word "including" is used, Alaska Statutes provide that it means "including, but not limited to."

5. Only the text that is being changed within a section of the current regulations is included in this draft. Refer to the text of that whole section, published in the current Alaska Administrative Code, to determine how a proposed change relates within the context of the whole section and the whole chapter.

7 AAC is amended by adding a new chapter to read:

Chapter 127. Community First Choice.

Section

010. Purpose

015. Services provided by family members

020. Community First Choice case management

025. Eligibility and enrollment for Community First Choice services

027. Disenrollment

030. Application for Community First Choice services; reapplication and reauthorization

035. Assessment; level-of-care determination

039. Support plan development; amendments to support plan

040. Community First Choice covered services

045. Community First Choice excluded services

050. Community First Choice services provider certification

055. Community First Choice provider decertification and disenrollment

060. Responsibilities of personal care assistants providing Community First Choice services

070. Provider termination of services to a recipient

075. Community First Choice place of service

085. Personal emergency response system services

090. Community First Choice personal care services service level authorization and reauthorization

095. Amendments to Community First Choice service level authorization

105. Employment of Community First Choice personal care assistants; qualifications

115. Consumer-directed and agency-based Community First Choice personal care services safety of recipients; safety of employees; termination of service

125. Consumer-directed Community First Choice personal care services recipient requirements

130. Consumer-directed Community First Choice personal care services provider agencies

135. Agency-based Community First Choice personal care services personal care assistant education and training requirements; supervising registered nurse

145. Reporting recipient changes

155. Critical incident reporting

160. Use of restrictive intervention

165. Review and appeal rights

190. Definitions

7 AAC 127.010. Purpose. The purpose of this chapter is to offer to individuals that meet the eligibility criteria in 7 AAC 127.025 the opportunity to choose to receive Community First Choice services as an alternative to institutional care. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.015. Services provided by family members. Community First Choice services covered under this chapter do not include services provided by a person who is the spouse of the recipient, the parent of a minor child that is the recipient, an individual with a duty to support the recipient under state law, the recipient's representative, or the representative's designee that was appointed in accordance with 7 AAC 125.125, unless an individual named in this section is a court-appointed guardian to a ward and a court authorizes the guardian under AS 13.26.316 to provide personal care services. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.020. Community First Choice services Long Term Services and Supports case management.

(a) The department will pay a provider agency for the Long Term Care Services and Supports Targeted Case Management services specified in 7 AAC 128.010 if the services are provided in accordance with the care coordination and provider Conditions of Participation adopted by reference in 7 AAC 160.900 by a care coordinator who is

(1) certified and enrolled under 7 AAC 130.238;

(2) employed by a provider agency authorized to provide Long Term Services and Supports Targeted Case Management services; and

(3) selected by an individual to provide those services except that the care coordinator may not be the individual eligible for Community First Choice services, a member of the individual's immediate family, the individual's representative, a person with a duty to support the individual under state law, a holder of power of attorney for the individual, or the individual's personal care assistant.

(b) A provider of Personal Care Services under 7 AAC Chapter 125 or Home and Community-based Waiver Services under 7 AAC Chapter 130, or those who have an interest in or are employed by a provider of Personal Care Services or Home and Community-based Waiver Services, may not provide services under this section for an individual unless the provider has been granted an exception under 7 AAC 130.220(j). (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.025. Eligibility and enrollment for Community First Choice services. (a) The department will pay a provider for Community First Choice services authorized in a recipient's service plan developed under 7 AAC 127.039, and provided in accordance with the applicable requirements of this chapter for an individual that is

(1) eligible for coverage under AS 47.07.020, 7 AAC 100.002, and (d) of this section; and

(2) enrolled under (e) of this section.

(b) A recipient is not eligible to receive Community First Choice services

(1) while an inpatient of a nursing facility, a hospital, institution for mental diseases, institution providing psychiatric services for individuals under age 21 or an intermediate care facility for individuals with intellectual disabilities; or

(2) if services, supports, devices, or supplies can be provided by services under 7 AAC 105 - 7 AAC 160 without the services specified under this chapter.

(c) A recipient enrolled in Community First Choice is eligible to receive Medicaid services for which the recipient is otherwise eligible.

(d) To determine eligibility for Community First Choice services under this section, the department will assess an individual annually to determine whether the individual requires a level of care provided in one of the following:

(1) a general acute care hospital or nursing facility, under 7 AAC 130.215;

(2) an intermediate care facility for individuals with intellectual disabilities, under 7 AAC 130.215;

(3) an institution providing psychiatric services for individuals under age 21, under 42 CFR. 456.481; or

(4) institution for mental diseases for individuals age 65 and over, under 42 CFR. 441.100.

(e) The department will consider the recipient to be enrolled under this section after the recipient has

(1) applied under 7 AAC 127.030;

(2) been assessed under 7 AAC 127.035;

(3) met the level-of-care requirement under (d) of this section; and

(4) received approval of the recipient's support plan under 7 AAC 128.039.

(f) The earliest date that an individual is eligible to receive Community First Choice services is the date when all of the requirements in (e) of this section have been met.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.027. Disenrollment. (a) The department will disenroll a recipient for any of the following reasons:

(1) the department terminates its participation in the Community First Choice program under 42 U.S.C. 1396n(k);

(2) the department is unable to determine eligibility for Community First Choice services because the documentation required for reassessment under 7 AAC 127.035 to determine the recipient's continuing eligibility for services was not submitted by the recipient, the recipient's representative, or the recipient's care coordinator at least 30 days before expiration of the current support plan year;

(3) the recipient is no longer eligible for Medicaid coverage under AS 47.07.020 or 7 AAC 100.002;

(4) the recipient is no longer eligible for services because the recipient's reassessment, conducted in accordance with 7 AAC 127.035, indicates the condition that made the recipient eligible for services has materially improved since the previous assessment, and

(A) the annual assessment and determination have been reviewed in accordance with AS 47.07.045(b)(2) using the department's

(i) *Material Improvement Reporting for CCMC Waivers*, adopted by reference in 7 AAC 160.900, if the recipient is under 21 years of age and in the recipient category of children with complex medical conditions;

(ii) *Material Improvement Reporting for IDD Participants under the Age of Three*, adopted by reference in 7 AAC 160.900, if the recipient is younger than three years of age and in the recipient category of individuals with intellectual and developmental disabilities;

(iii) *Material Improvement Reporting for IDD Participants Age Three or Over*, adopted by reference in 7 AAC 160.900, if the recipient is three years of age or older and in the recipient category of individuals with intellectual and developmental disabilities; or

(iv) *Material Improvement Reporting for ALI/APDD Waivers*, adopted by reference in 7 AAC 160.900, if the recipient is in the recipient category of older adults or adults with physical disabilities or in the recipient category of adults with physical and developmental disabilities; and

(B) the reviewer confirms to the department that the condition that made the recipient eligible for services has materially improved;

(5) the recipient or the recipient's representative chooses to end the recipient's participation in the Community First Choice program;

(6) the recipient or the recipient's representative misrepresents the recipient's physical, intellectual, developmental, or medical condition in an effort to obtain services that are not medically necessary or for which the recipient does not quality;

(7) the recipient has a documented history of failing to cooperate with the delivery of services identified in the support plan prepared under 7 AAC 127.039, or of placing caregivers or other recipients at risk of physical injury, and no other providers are willing to provide services to the recipient; for the purposes of this paragraph, a documented history exists if a provider

(A) reports that the provider has been unable obtain cooperation with service delivery or to mitigate the risk of physical injury to a caregiver or other recipients through reasonable accommodation of the recipient's disability; and

(B) maintains records to support that report, and makes those records available to the department for inspection; the department will review those records before making a decision on disenrollment under this paragraph;

(8) the recipient or the recipient's representative fails to take an action or to submit documentation required under 7 AAC 127.025 - 7 AAC 127.165.

(b) An applicant or recipient that is denied enrollment for Community First Choice services or a recipient that is disenrolled for reasons described in (a) of this section, may appeal that decision under 7 AAC 49. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.045
AS 47.07.030 AS 47.07.040

7 AAC 127.030. Application for Community First Choice services; reapplication and reauthorization. (a) The department will pay for and review, in any 365-day period, one initial application for Community First Choice services to determine whether there is a reasonable indication that the individual might need services at a level of care under 7 AAC 127.025(d).

(b) To apply for Community First Choice services under this chapter, an individual must

(1) participate in the person-centered intake process;

(2) select a care coordinator under 7 AAC 127.025(a) and participate in pre-enrollment option counseling; and

(2) with the assistance of the care coordinator, complete an application in a format provided by the department.

(c) A recipient that wishes to have Community First Choice services reauthorized must request the recipient's care coordinator to submit to the department a complete application not later than 60 days before the expiration of the recipient's current support plan.

(d) Not later than 14 business days after the date the application is received, the department will send to the individual and the individual's care coordinator notice in writing of any missing information or documentation needed to make the application complete. Unless the department receives the missing information or documentation not later than 15 business days after the date of the notice of an incomplete application, the department will deny the application.

(e) The department will consider a request for an expedited review of an application if

(1) the request is submitted in a format provided by the department with a complete application or with a request for an amendment of a service plan; and

(2) the department determines on the basis of the request and application or amendment that the individual has no natural supports to meet the individual's needs and the individual qualifies because of

(A) a diagnosis of terminal illness with a life expectancy of six months or less;

(B) imminent or recent discharge from a general acute care hospital or nursing facility; the individual must submit the application not later than seven days after the date of discharge

(C) an unplanned absence of the primary caregiver due to a medical or family emergency or to hospitalization;

(D) the declining health of the primary caregiver that makes that caregiver unable to continue to provide care for the individual;

(E) the death of the primary caregiver 30 or fewer days before the date of the application;

(F) a referral from the departmental office responsible for adult protective services or children's services; or

(G) a request by a personal care services agency certified under 7 AAC 127.050 for a time-limited increase in Community First Choice personal care services, not to exceed six consecutive weeks, to address an individual's immediate need if that need is related to the individual's functional capacity to perform the services covered under 7 AAC 124.130. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.035. Assessment; level-of-care determinations. (a) Not later than 30 business days after the department determines that an application is complete, and the application and supportive diagnostic documentation reasonably indicate the need for services described in 7 AAC 127.040, the department will

(1) conduct an assessment or reassessment of the individual using the *Consumer Assessment Tool* adopted by reference in 7 AAC 160.900 to determine if the individual

(A) meets a level of care provided in an institution as specified in 7 AAC 127.025; and

(B) qualifies to receive Community First Choice personal care services.

(2) send a letter to the individual and the individual's care coordinator indicating

(A) the level-of-care determination;

(B) whether development of a support plan under 7 AAC 127.039 may proceed; and

(C) if the individual qualifies to receive Community First Choice personal care services, the level of assistance authorized for those services.

(b) Notwithstanding (a) of this section, the department may extend the notification timeframe for an additional 30 business days if the department requests review by an independent qualified health care professional in accordance with AS 47.07.045(b), and 7 AAC 127.027(a)(4) or 7 AAC 130.219(e)(4). (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.039. Support plan development; amendments to support plans. (a) Not less than once every 12 months, the care coordinator shall submit a support plan based on the current needs of the recipient, the most recent assessment or reassessment conducted under 7 AAC 127.035, and the level-of-care determination made in accordance with 7 AAC 127.025. After an assessment or reassessment under 7 AAC 127.035, and after receiving the department's

notice that the recipient meets the level-of-care requirement under 7 AAC 127.025, the care coordinator shall

(1) inform the recipient regarding

(A) the care coordinator's relationship as an employee of any provider certified under 7 AAC 130.220 and 7 AAC 127.050 and of any relationship described in 7 AAC 130.240(f);

(B) the Community First Choice services and other long term services and supports available to the recipient and the names of all providers that offer those services; and

(C) the recipient's right to free choice of providers, including the right to choose another care coordinator to develop the recipient's support plan; the care coordinator shall support the recipient in the recipient's exercising the right to free choice of providers;

(2) consult, in person or by electronic mail, telephone, or videoconference, with each member of a planning team that

(A) at a minimum, includes

(i) the recipient;

(ii) the recipient's representative;

(iii) members chosen by the recipient; and

(iv) a representative of each provider certified under 7 AAC 130.220 and 7 AAC 127.050 that is expected to provide services to the recipient, except that a provider of specialized medical equipment, transportation services, or environmental modification services is not required to be represented on the planning team; and

(B) at the request of the recipient or the recipient's representative, includes the recipient's family members and others that provide informal supports for the recipient;

(3) prepare in writing, in a format provided by the department, a support plan that

(A) identifies the needs of the recipient for specific services;

(B) identifies the providers certified under 7 AAC 130.220 and 7 AAC 127.050 that are available to render services to the recipient;

(C) identifies a recipient backup plan in the event that Community First Choice services are not available;

(D) identifies for each Community First Choice service and other long term services and supports

(i) the provider certified under 7 AAC 130.220 and 7 AAC 127.050 that has agreed to provide that service;

(ii) the number of units of that service;

(iii) the frequency of that service; and

(iv) the projected duration of that service; and

(E) includes an analysis of whether each service and amount of that service is consistent with

(i) the assessment or reassessment conducted under 7 AAC 127.035 and the level-of-care determination made in accordance with 7 AAC 127.025; and

(ii) any treatment plans developed for the recipient;

(4) secure the signature, either in person or electronically, of

(A) the recipient or recipient's representative indicating that the recipient or recipient's representative

(i) agrees to the support plan;

(ii) has been informed of any relationship between the care coordinator and any provider certified under 7 AAC 130.220 and 7 AAC 127.050 and of any relationship described in 7 AAC 130.240(f); and

(iii) has been informed of the recipient's right to free choice of providers;

(B) each provider representative indicating the provider agrees to render the services as specified in the support plan; and

(C) each individual on the planning team to verify participation in the development of the recipient's support plan; any disagreement among planning team members about outcomes or service levels, or any suggestion by a team member that an outcome or service level should be different than one established in the support plan, must be documented and attached to the support plan; and

(5) submit the support plan and supporting documentation to the department ; unless the care coordinator has submitted to the department written documentation of unusual circumstances that prevent timely completion of the support plan, and the department has approved a later submission date, the care coordinator shall submit the support plan not later than

(A) 60 days after the date of the department's notice to the recipient and the recipient's care coordinator that the recipient meets the level-of-care requirement in 7 AAC 127.025;

(B) 30 days before expiration of the current support plan year.

(b) The department will approve a support plan if the department determines that

(1) the services specified in the support plan meet the needs of the recipient;

(2) each service listed on the support plan

(A) is of sufficient amount, duration, and scope to meet the needs of the recipient;

(B) is supported by the documentation required in this section; and

(C) cannot be provided under 7 AAC 105 - 7 AAC 160, except as Community First Choice services under this chapter or Home and Community-based Waiver services under 7 AAC 130.200 – 130.319.

(c) Not later than 30 business days after the department receives a recipient's complete support plan, the department will notify the recipient, the recipient's representative, and the recipient's care coordinator of the department's approval or disapproval of specific services.

(d) At the request of the recipient for a change in the recipient's personal care services, the recipient's care coordinator or the provider agency shall

(1) prepare an amendment to the recipient's support plan if

(A) a modification is required to meet the recipient's needs because of a change of circumstances related to the health, safety, and welfare of the recipient; or

(B) the recipient needs an increase or decrease in the number of service units approved under (a) - (c) of this section or in a prior amendment to the support plan;

(2) secure the signature, either in person or electronically, of

(A) the recipient or recipient's representative indicating that the recipient or recipient's representative agrees to the support plan amendment; and

(B) a representative of each provider of services that are modified by the amendment indicating the provider agrees to render the services as specified in the support plan amendment; and

(3) submit the support plan amendment to the department not later than 10

business days after the date of a change in circumstances or a change in the number of service units was requested, unless the care coordinator has submitted to the department written documentation of unusual circumstances that prevent timely completion of a support plan amendment, and the department has approved a later submission date.

(e) Not later than 30 business days after the department receives a complete support plan amendment, the department will notify the recipient, the recipient's representative, and the recipient's care coordinator of the department's approval or disapproval of specific services.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.045
AS 47.07.030 AS 47.07.040

7 AAC 127.040. Community First Choice covered services. (a) The department will pay a Community First Choice provider agency for the following services for individuals eligible under 7 AAC 127.025, if those services are provided in accordance with 7 AAC 127.010-127.190:

(1) personal emergency response services under 7 AAC 127.085;

(2) assistance, including supervision and cueing, with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as specified in 7 AAC 125.030, and

(3) acquisition, maintenance, and enhancement of skills necessary for the recipient to accomplish the activities in 7 AAC 125.030(b) - (d).

(b) If a recipient indicates during the development of the support plan that the recipient would like to receive the service specified in (a)(3) of this section to enable the recipient to perform independently the ADLs and IADLs and other services identified on the Community

First Choice Service Level Authorization, the care coordinator may request time for training in the recipient's support plan. The department may approve a request for such training for not more than three consecutive months in the recipient's life time; if approved, the training

(1) will be limited to not more than three percent of the recipient's total number of hours authorized under (a) of this section; and

(2) may not duplicate other habilitation services under 7 AAC 130.260 or 7 AAC 130.265.

(c) The department will authorize a recipient to receive specific services in (a) of this section after an assessment under 7 AAC 127.035 establishes the individual's need for the services.

(d) A recipient that is eligible for both chore services under 7 AAC 130.245 and services under (a)(2) of this section must choose either to receive chore services or to have similar activities performed as personal care services.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.045. Community First Choice excluded services. The department will not pay for the following as Community First Choice services reimbursable under Medicaid:

(1) room and board costs;

(2) special education and related services provided under the Individuals with Disabilities Education Act that are related to education only, and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

(3) assistive devices and assistive technology services, other than as provided in 7 AAC 127.085;

(4) medical supplies and medical equipment available to the recipient under the Medicaid state plan;

(5) home modifications. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.050. Provider agency certification for Community First Choice services.

(a) The department will certify a provider agency for only the Community First Choice services under 7 AAC 127.040 that the provider agency is qualified to offer.

(b) To receive payment for Community First Choice services, a provider must enroll in the Medicaid program under 7 AAC 105.210 and must be certified under this section. To be certified by the department a provider must

(1) submit an application and meet the applicable certification criteria, including the provider qualifications and program standards, set out in the department's *Personal Care Services and the Community First Choice Personal Care Services Provider Conditions of Participation*, adopted by reference in 7 AAC 160.900; and

(2) for each service under (a) of this section that the provider plans to offer, comply with the

(A) provisions of this chapter applicable to each service; and

(B) Conditions of Participation applicable to that service, adopted by reference in 7 AAC 160.900.

(c) The department will certify a provider under this section for the following time periods:

(1) one year for a provider not previously certified by the department to provide Community First Choice services;

(2) two years for a currently certified provider that is renewing that provider's certification.

(d) Not later than 90 days before the expiration of a provider's certification, the department will send to the provider notice of the requirement to renew that certification. The provider must submit an application to renew certification and all required documentation not later than 60 days before the expiration date of the current certification.

(e) A certified provider under this chapter shall comply with this chapter and the requirements of 7 AAC 105.200 - 7 AAC 105.280. The department will determine compliance through monitoring, including audits, reviews, and investigations, that may take place at the provider's place of business or at any site where services under this chapter are provided. The department will conduct compliance reviews under 7 AAC 125.190, and may

(1) request, in accordance with 7 AAC 105.240, records related to the services provided under this chapter; or

(2) take immediate custody of a provider's original records, maintained in accordance with 7 AAC 105.230, if the department has reason to believe, based on an audit, program review, or investigation, that those records are at risk of alteration; once records are in the custody of the department, the provider may make copies of those records only under the supervision of the department.

(f) In addition to the authority under 7 AAC 105.400 - 7 AAC 105.490 to take action in regard to certification, the department will deny an initial application or an application to renew certification of a provider agency as a provider of Community First Services if

(1) the provider fails to submit a complete application under (a) of this section so that it is received by the department not later than 30 days after the date of notice from the department that the application is incomplete;

(2) the provider's certification, license, or enrollment related to Medicaid or Medicare was denied, revoked, or rescinded;

(3) the provider's name appears on any state or federal exclusion list related to health care services;

(4) the department has documentation that indicates the provider is unable or unwilling to meet the certification requirements of this section or any other Medicaid requirement under 7 AAC 105 - 7 AAC 160;

(5) the department has evidence that the owner or the administrator of a provider agency does not operate honestly, responsibly, and in accordance with applicable laws in order to maintain the integrity and fiscal viability of the medical assistance program; or

(6) based upon evidence from an audit, provider review, or investigation, the department has probable cause to believe that the provider's noncompliance with the Medicaid program or this chapter causes immediate risk to the health, safety, or welfare of a recipient or would be considered to be fraud, abuse, or waste.

(g) If the department denies an initial application or an application to renew certification of a provider, the department will send, not later than 14 business days after the date of the

decision, written notice of the action and information regarding the provider's right to appeal the decision under AS 44.64.

(h) Instead of decertification or suspension, the department may

(1) notify the provider of the department's findings that form the basis for possible decertification or suspension;

(2) specify a date on or before which the provider must submit a written corrective action plan that includes the method by which the provider will verify compliance and the expected date of compliance;

(3) approve or require revision of the corrective action plan as written or specify other dates for compliance; and

(4) monitor the provider's progress toward meeting the requirements of the corrective action plan; if the department finds that the provider has not met the requirements of the corrective action plan on or before the date compliance is required, the department may decertify or suspend the provider as provided in (f) of this section.

(i) Notwithstanding the provisions of this section, if the department has reasonable cause to believe that the health, safety, or welfare of a recipient is at risk, the department may immediately suspend or revoke a provider's certification. If the department immediately suspends or revokes certification under this subsection, the department will

(1) give the provider initial notice, oral or written, of the suspension or revocation of certification, including information regarding the right to appeal; if no one is present to receive the notice, the department will post the notice on the main entrance to the building in which the provider agency is located; and

(2) not later than 14 business days after the date of the suspension or revocation of certification issue a formal report that includes information related to the action taken, the reason for the action, and the right to appeal.

(j) The department may enter into a contract under AS 36.30, a grant, or other arrangement permitted by law, with a provider or tribal health program authorizing that provider or tribal health program to provide personal care services to a specific group or in a specific geographical area.

(k) A provider of Community First Choice services shall comply with the accounting, reporting, and cost survey requirements of 7 AAC 145.531 - 7 AAC 145.537.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.055. Provider decertification and disenrollment. (a) The department may deny enrollment or certification to, or disenroll or decertify, a provider agency as a provider of Community First Choice services

(1) if the agency does not meet the requirements in the department's certification application under 7 AAC 127.050;

(2) for grounds and under procedures set out in 7 AAC 105.400 - 7 AAC 105.490;

(3) if the agency is no longer qualified for certification under 7 AAC 105 – 7 AAC 160; or

(4) if the department determines under 7 AAC 10.900 – 7 AAC 10.990 that a barrier crime or condition exists with respect to an employee of a provider agency or revokes a

background check under 7 AAC 10.945, and the provider agency does not terminate association with the employee in accordance with 7 AAC 10.960, unless the department grants a redetermination under 7 AAC 10.927 or grants a variance under 7 AAC 10.930 or 7 AAC 10.935.

(b) Instead of decertification or suspension, the department may

(1) notify the provider of the department's findings that form the basis for possible decertification or suspension; and

(2) specify a date on or before which the provider must submit a written corrective action plan that includes the method by which the provider will verify compliance and the expected date of compliance;

(3) approve or require revision of the corrective action plan as written or specify other dates for compliance and

(4) monitor the provider's progress toward meeting the requirements of the corrective action plan; if the department finds that the provider has not met the requirements of the corrective action plan on or before the date compliance is required, the department may decertify or suspend the provider as provided in (a) of this section.

(b) Providers that have been disenrolled or decertified by the department under (a)(2) or (3) of this section may appeal that decision under 7 AAC 105.460.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.060. Responsibilities of personal care assistants providing Community First Choice services. (a) A personal care assistant employed by an agency providing Community First Choice services shall maintain, for Medicaid billing purposes, a contemporaneous record for of services provided to each recipient. The record must include

(1) a copy of the service level authorization signed by, or bearing the legal mark of, the recipient, the recipient's representative, or the representative's designee appointed in accordance with 7 AAC125.100 (c), and the department or its designee;

(2) documentation of services performed under the support plan, including case notes, frequency, scope, and duration;

(3) a copy of any amendments to the recipient's support plan prepared under 7 AAC 128.010, and approved by the department;

(4) a copy of the support plan signed by, or bearing the legal mark of, the recipient or the recipient's legal representative and the department or its designee; documentation, in the form of case notes, of services provided in accordance with the support plan;

(5) time sheets that indicate

(A) the date, time, and length of each visit, and the services provided during each visit; and

(B) for each visit, the signature or legal mark of the recipient, the recipient's representative, or the representative's designee appointed in accordance with 7 AAC125.100 (c) verifying that the services were provided as reported by the personal care assistant.

(b) If a recipient chooses to receive Community First Choice services from another

provider agency or personal care assistant, or discontinues a Community First Choice services provider agency, the former provider agency or agency service worker shall deliver the record required by (a) of this section to the appropriate Community First Choice services provider agency chosen by the recipient not more than two business days after the date of the change or discontinuation.

(c) If a personal care assistant terminates employment, the personal care assistant shall deliver the record required by (a) of this section to the appropriate Community First Choice services provider agency not more than two business days after the date of termination.

(d) A personal care assistant may not

(1) accept payment in any form from a recipient for any Medicaid-reimbursable service; or

(2) solicit clients for direct care services.

(e) A personal care assistant shall keep all information concerning a recipient confidential in accordance with P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996).

(f) A personal care assistant is subject to the reporting requirements of AS 47.17.020 and AS 47.24.010.

(g) If a personal care assistant is charged with, convicted of, found not guilty by reason of insanity for, or adjudicated as a delinquent for a barrier crime listed in 7 AAC 10.905,

(1) the personal care assistant shall inform the Community First Choice services provider agency not more than 24 hours, or not later than close of business the next business day, whichever is first, after the date that the personal care assistant was charged, convicted, found not guilty by reason of insanity, or adjudicated as a delinquent; and

(2) the Community First Choice services provider agency shall notify the

department as required under 7 AAC 10.925(b).

(h) A personal care assistant worker shall notify the Community First Choice services provider agency not more than 10 days after a change in the personal care assistant's

(1) name;

(2) license, certification, or registration status; or

(3) mailing address, physical address, or telephone number.

(i) In this section, "case notes" means progress notes documented after or as services are provided, that

(1) include the date, time in and time out, activities provided, and how the recipient responded to care;

(2) identify any changes, improvement, or decline in the recipient's health, safety, or welfare, including changes in physical or mental conditions;

(3) are dated and signed by the personal care assistant who provided the services; and

(4) are contained in and retained as part of the recipient's service record.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.070. Provider termination of services to a recipient. (a) Not later than 30 days before a provider of Community First Choice services terminates services for a recipient, the provider agency shall send written notice of service termination to the department, the recipient, and the recipient's care coordinator.

(b) A provider agency may terminate services to a recipient without the notice required in (a) of this section if the provider agency has evidence that

(1) continuing services for the recipient will

(A) jeopardize the safety of the provider, an employee of the provider, or an individual receiving services from the provider; or

(B) endanger the health, safety, and welfare of the recipient; and

(2) documents measures that the provider agency took to address the recipient circumstances that resulted in immediate termination of the recipient.

(c) A Community First Choice services provider that terminates services to a recipient under (b) of this section shall

(1) comply with the requirements of (a) of this section, except for the 30-day time frame for notice of termination; and

(2) refer the recipient to the office of the department responsible for adult protective services or child protective services as appropriate, if the provider has any concern that the immediate termination of services will place the recipient at risk of harm.

(d) A provider that intends to close, sell, or change ownership of a business certified under 7 AAC 127.050, shall send written notice of that intention to the department and to each affected recipient and that recipient's care coordinator not later than 60 days before the closure, sale, or change in ownership. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.075. Community First Choice personal care services place of service. (a) Community First Choice personal care services may be provided only to a recipient who is living in the recipient's personal residence.

(b) The following living situations are excluded as a recipient's personal residence for the purposes of Medicaid payment for Community First Choice personal care services:

(1) a licensed skilled nursing or intermediate care facility or hospital;

(2) a licensed intermediate care facility for individuals with an intellectual disability or related condition;

(3) an assisted living home licensed under AS 47.32;

(4) an unlicensed residential setting the at the department determines to fall within the definition of an assisted living home under AS 47.32.900;

(5) a residence where Community First Choice personal care services are provided under a contractual agreement;

(6) a general acute care hospital. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.085. Personal emergency response system services. (a) The department will pay for a personal emergency response system that

(1) is supported by written documentation that includes

(A) a statement specifying that the system requested is appropriate for the recipient's needs; and

(B) a recommendation for the system from an individual with an active license to practice under AS 08 or 7 AAC 105.200 (c) as a physician, a physician assistant, an advanced practice registered nurse, an occupational therapist, or a physical therapist; and

(2) is supported by a written cost estimate;

(3) is approved under 7 AAC 127.039 as part of the recipient's support plan; and

(4) receives prior authorization.

(b) The department will consider an item to be a personal emergency response system if that system

(1) includes a device, control, or appliance that, for a system use fee, communicates directly with emergency response personnel for calls for assistance in an emergency; and

(2) identified in the department's Specialized Medical Equipment Fee Schedule, adopted by reference in 7 AAC 160.900.

(c) The department will pay under this section subject to the following:

(1) the unit cost of equipment is determined by including the cost of

(A) training in the proper use of the equipment; and

(B) routine fitting of and maintenance on the equipment necessary to meet applicable standards of manufacture, design, and installation;

(2) personal emergency response system equipment may be rented if the department determines that renting the equipment is more cost-effective than purchasing it;

(3) once purchased, personal emergency response equipment becomes the property of the recipient.

(d) The department will not

(1) give prior authorization to replace personal emergency response system equipment before the expiration of the time period identified in the department's Specialized Medical Equipment Fee Schedule, adopted by reference in 7 AAC 160.900, unless the department determines that replacement is more cost-effective than repairing that equipment; or

(2) pay for a personal emergency response system as a Community First Choice service, if the cost of is payable under 7 AAC 120.200 - 7 AAC 120.299.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.090. Community First Choice personal care services service level authorization and reauthorization. (a) For each recipient, based upon that recipient's assessment conducted under 7 AAC 127.035, the department will

(1) determine the level of assistance necessary for and the amount, duration, and frequency of the specific personal care services for which the department will pay using the *Community First Choice Personal Care Assistance Service Level Computation*, adopted by reference in 7 AAC 160.900; and

(2) develop a Community First Choice personal care service level authorization that identifies the specific ADLs, IADLs, and other services covered under 7 AAC 127.040.

(b) The total number of hours authorized under (a)(1) of this section may be used to provide any activity or other service covered under 7 AAC 127.040 that is identified in the individual's support plan developed under 7 AAC 127.039.

(c) The department will not pay a provider for any activity or service that is not specified in 7 AAC 127.040, or is not identified in a recipient's support plan.

(d) A recipient's Community First Choice personal care service level authorization or an amendment to a Community First Choice personal care service level authorization developed under this section does not take effect until approved by the department.

(e) The department may authorize Community First Choice services for a specific length of time not to exceed a 12-month period. A request for reauthorization must be accompanied by a new assessment under 7 AAC 127.035. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.095. Amendments to service level authorization for Community First Choice personal care services. (a) The department may increase, or reduce the time authorized for Community First Choice personal care services before the end of a recipient's current authorization period if the department determines that a recipient

(1) has experienced a change that alters the recipient's need for assistance with ADLs, IADLs, or other covered services after the recipient's last assessment or amendment to the service level authorization;

(2) the recipient's living environment, support services, or informal supports or caregivers changed after the recipient's last assessment; or

(3) the recipient received Community First Choice services that are no longer authorized under 7 AAC 105 - 7 AAC 160.

(b) To request an amendment to a service level authorization before the end of the recipient's current authorization period, the recipient's care coordinator must

(1) complete and submit the request in the format provided by the department for that purpose; and

(2) submit current medical or other relevant documentation that supports the claim that the change alters the recipient's need for physical assistance with ADLs, IADLs, or other covered services.

(c) Before reducing the time authorized for a recipient for Community First Choice personal care services, the department will first consider whether a reduction in the time authorized for the recipient's Community First Choice personal care services would create a risk of institutionalization. The department will consider the following to make this determination:

(1) the documents specified in 7 AAC 127.030 that are current and submitted by the recipient in response to the department's notification requiring a new assessment;

(2) the findings on the recipient's *Consumer Assessment Tool* that are the result of a new assessment;

(3) the impact of a reduction in time measured over a 24 hour period, taking into consideration the total time that the recipient receives physical assistance from any source;

(4) whether the recipient's representative, family members, or other natural supports provide assistance to the recipient;

(5) whether other individuals living in the same residence as the recipient receive services that benefit the recipient; and

(6) the recipient's history of utilization of the time authorized on the recipient's current service level authorization.

(d) In this section, "risk of institutionalization" means it is likely that as a result of the recipient's current condition as identified in assessments and medical records, the recipient would require relocation from the recipient's current residence to a hospital or nursing facility in 30 days. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.105. Employment of Community First Choice personal care services personal care assistants; qualifications. (a) To receive payment for Community First Choice personal care services, a personal care assistant must be employed in either a consumer-directed program or an agency-based program, and must

(1) be at least 18 years of age;

(2) meet all requirements for the position as set out in 7 AAC 125.010 – 7 AAC 125.199;

(3) have on file documentation of successful completion of training to assist a recipient to learn the skills necessary to perform independently the personal care services specified in a recipient's service level authorization, in addition to training requirements 7 AAC 125.010 – 7 AAC 125.199.

(b) A Community First Choice personal care services provider agency is subject to the applicable requirements of AS 47.05.300 - 47.05.390 and 7 AAC 10.900 - 7 AAC 10.990. The personal care agency shall submit to the department a request for a criminal history check for each personal care assistant as required under 7 AAC 10.910. The department will not pay for services provided by a personal care assistant

(1) for whom a criminal history check was not requested as required under 7 AAC 10.900 - 7 AAC 10.990; or

(2) who does not pass a criminal history check under 7 AAC 10.900 - 7 AAC 10.990; however, except as restricted by applicable federal law, the department will not withhold payment if it grants a provisional valid criminal history check under 7 AAC 10.920 or a variance under 7 AAC 10.935. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.115. Consumer-directed and agency-based Community First Choice personal care services safety of recipients; safety of employees; termination of service.

(a) An agency certified, in accordance with 7 AAC 127.050, as a provider of Community First Choice services shall

(1) protect a recipient's health, safety, and welfare while rendering services under this chapter; and

(2) provide training for all employees regarding

(A) the mandatory reporting requirements of AS 47.17.020 for children and AS 47.24.010 for vulnerable adults;

(b) the critical incident reporting requirements of 7 AAC 127.155.

(b) Not later than 30 days before an agency terminates Community First Choice personal care services to a recipient, the agency shall send written notice of the termination to the department and to the recipient.

(c) In addition to the requirements of (a) of this section, an agency must follow the

requirements under 7 AAC 125.110.

(d) An agency that intends to close, sell, or change ownership of or a percentage of ownership in, shall send written notice of that intention to the department and to each affected recipient not later than 60 days before the closure, sale, or change in ownership.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.125. Consumer-directed Community First Choice personal care services recipient requirements. (a) To qualify for personal care services through a consumer-directed program, a recipient, a recipient's representative, or representative's designee, identified in accordance with (e)(2) of this section, must

(1) demonstrate cognitive capacity for decision-making;

(2) understand the impact of and assume responsibility for managing and training the recipient's personal care assistants;

(3) designate a provider agency that administers a consumer-directed personal care services program to fulfill the responsibilities of 7 AAC 127.130 on behalf of the recipient;

(4) cooperate with department staff or the department's designee in reviews of the recipient's level of care assessment and service level authorization;

(5) cooperate with department staff or the department's designee and with other state and federal oversight agencies during compliance reviews, investigations, or audits; and

(6) negotiate a contract for the recipient's personal care services with the personal care services provider agency that will administer those services through a consumer-directed

program.

(b) The recipient, the recipient's representative, or the representative's designee is responsible for

(1) designating individuals who will render services to the recipient as personal care assistants as specified in the recipient's Community First Choice service level authorization developed in accordance with 7 AAC 127.045;

(2) training and scheduling the personal care assistants;

(3) supervising, and signing the timesheets of, the personal care assistants;

(4) terminating employment of the personal care assistants if services are unsatisfactory or no longer needed.

(c) A recipient, the recipient's representative, or the representative's designee must notify the Community First Choice services provider agency not more than five days after

(1) the date that the needs of the recipient for personal care services changes; or

(2) the name or the address of the recipient, the recipient's representative, or the recipient's designee changes.

(d) If a recipient has a documented history of self-neglect or is found, during an assessment under 7 AAC 127.035, to lack the cognitive capacity to manage the recipient's personal care services, the department will pay for agency-based personal care services only; "self-neglect" has the meaning given in AS 47.24.900(13).

(e) Notwithstanding (d) of this section, the department may pay for consumer-directed personal care services for a recipient found to lack cognitive capacity during an assessment if

(1) the recipient demonstrates, to the department's satisfaction in additional documentation, that the recipient does have the cognitive capacity to manage the recipient's

personal care services; the recipient must submit in a format provided by the department, a statement that indicates the recipient is capable of managing the recipient's own care and that is signed by the recipient's physician, physician assistant or advanced practice registered nurse that is licensed under AS 08, or is described in 7 AAC 105.200 (c); or

(2) the recipient submits to the department a document, dated prior to the application under 7 AAC 127.030, that identifies the recipient's representative and specifies the representative's authority, and that representative

(A) qualifies under (a) of this section and accepts responsibility for the activities required under (b) of this section; or

(B) designates, in accordance with 7 AAC 125.100, an individual that qualifies under (a) of this section and accepts responsibility for the activities required in (b) of this section. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.130. Consumer-directed Community First Choice personal care services provider agencies. (a) In addition to meeting the requirements under 7 AAC 127.010 - 7 AAC 127.190, a personal care services agency that administers a Community First Choice consumer-directed program shall

(1) perform, at least once every six months, a review of the recipient's services, including

(A) interviewing the recipient at the recipient's residence to assure that services are provided, and those services meet the recipient's needs;

(B) evaluating the service records, including timesheets prepared by the recipient's personal care assistant;

(C) verifying in writing that the services provided are consistent with the recipient's Community First Choice support plan;

(D) recommending to the department amendments to the recipient's Community First Choice support plan when the recipient's needs change, and the reasons for the recommendations;

(2) maintain communications with the recipient, the recipient's health care providers, as appropriate, and the personal care assistant;

(3) maintain a service record for each recipient that includes

(A) copies of each Community First Choice support plan, assessment, and documentation of reviews under (a)(1) of this section , including amendments under 7 AAC 127.030 and 7 AAC 127.095;

(B) copies of the personal care assistant's timesheets, signed by the recipient, the recipient's representative, or the representative's designee; and

(C) records of contacts that are related to the health, safety, and welfare of the recipient and are between the provider agency and the recipient, the recipient's health care providers, as appropriate, and the personal care assistant.

(b) The department may waive the required mid-year review of the recipient in the recipient's residence in accordance with (a)(1)(A) of this section if

(1) the recipient's residence is in a remote community or location;

(2) the provider agency performs a review of the recipient's services at least once in a 12 month period;

(3) the provider agency arranges for a telephonic or electronic meeting with the recipient and the recipient's personal care assistant for the mid-year review of services; and

(3) the provider agency requests a waiver in a format provided by the department, and documents to the department's satisfaction that a waiver of the mid-year review will not compromise the health, safety, or welfare of the recipient.

(c) A provider agency shall collect and verify consumer-directed personal care assistant's timesheets, and submit claims based on those timesheets to the department.

(d) A provider agency that administers a consumer-directed program and either the recipient or the recipient's representative shall work with the care coordinator to:

(1) identify possible risks for the recipient when needed assistance might not be available; and

(2) develop a backup plan that

(A) identifies the responsibilities of provider the agency and the recipient for obtaining the personal care services if the recipient's regularly scheduled personal care assistant is unable to provide those services; and

(B) develop a backup plan that identifies the responsibilities of the provider agency and the recipient for obtaining personal care services or other backup services to be implemented if the recipient's regularly scheduled personal care assistant is unable to to provide those services. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.135. Agency-based Community First Choice personal care services personal care assistant education and training requirements; supervising registered nurse. An agency that manages an agency-based Community First Choice personal care services program shall

(1) employ personal care assistants that meet the requirements of 7 AAC 125.160; and

(2) retain a supervising licensed registered nurse and meet the requirements under 7 AAC 125.170. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.145. Reporting recipient changes. (a) A recipient shall report to each of the recipient's Community First Choice services providers and the recipient's care coordinator any of the following changes by telephone, by facsimile transmission, by electronic mail, in writing, or in person not later than 15 days after the recipient knows of the change:

(1) a change in the recipient's

(A) place of residence or living arrangement;

(B) personal contact information;

(C) representative;

(D) medical provider;

(E) marital status;

(2) a change to the recipient's eligibility to receive Home and Community-based Waiver Services under 7 AAC 130.200 – 7 AAC 130.319, or other health care services that duplicate the recipient's Community First Choice personal care services;

(3) an improvement or decline in the recipient's physical condition; or

(4) a change to the household composition or in the number of recipients receiving services in the recipient's residence.

(b) Not later than 15 days after the Community First Choice service provider agency learns of the change, the provider agency shall report, in a format provided by the department, any change that could affect the recipient's level of care assessment, service level authorization or the level of services provided to the recipient; the provider agency may submit the report by facsimile transmission, by electronic mail, in writing, or in person.

(c) Upon review of a report under (a) or (b) of this section, the department may conduct a new assessment of a recipient if the department determines that reassessment is necessary to confirm the recipient's eligibility for Community First Choice services, or need for services at the level of assistance or for the activities specified in recipient's current services level authorization. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.155. Critical incident reporting. (a) A provider of Community First Choice personal care services shall report to the department, in a format provided by the department, a critical incident involving a recipient not later than one business day after observing or learning of the critical incident.

(b) A provider agency shall develop and implement a system to manage and report critical incidents that includes

(1) methods for identifying a critical incident;

(2) a protocol for emergency response to a critical incident;

(3) procedures for investigating and analyzing a critical incident to determine its cause;

(4) a plan to ensure that each member of the provider's staff is trained in critical incident management and reporting; and

(5) a process that ensures timely reporting of a critical incident

(A) to the department and the recipient's representative; and

(B) to other service providers when necessary to protect recipient health, safety, and welfare; the provider shall maintain a record of names of the providers that are sent incident reports and the date sent.

(c) A provider of personal care services that terminates services to a recipient under 7 AAC 127.115 shall refer the recipient to the office of the department responsible for adult protective services or the office of the department responsible for children's services, as appropriate, if the provider has any concern that immediate termination of the provider's services will place the recipient at risk of harm.

(d) In this section,

(1) "critical incident" means

(A) a missing recipient;

(B) recipient behavior that resulted in harm to the recipient or others;

(C) misuse of restrictive interventions; in this subparagraph, "restrictive intervention" has the meaning given in 7 AAC 125.104(g);

(D) a use of restrictive intervention that resulted in the need for evaluation by or consultation with medical personnel; in this subparagraph, "restrictive intervention" has the

meaning given in 7 AAC 125.104(g);

(E) death of a recipient;

(F) an accident, an injury, or another unexpected event that affected the recipient's health, safety, or welfare to the extent evaluation by or consultation with medical personnel was needed;

(G) a medication error that resulted in the need for evaluation by or consultation with medical personnel;

(H) an event that involved the recipient and a response from a peace officer;

(2) "evaluation by or consultation with medical personnel" means analysis of the incident with respect to a recipient's health, safety, and welfare for the purpose of determining an appropriate treatment or course of action;

(3) "medication error" means

(A) a failure to document assisting a recipient with self-administration of prescribed oral medication, eye drops, and skin ointments; in this subparagraph, "assisting a recipient with self-administration of prescribed oral medication, eye drops, and skin ointments" has the meaning given in 7 AAC 125.030(g);

(B) a failure to assist a recipient with self-administration of prescribed oral medication, eye drops, and skin ointments at, or within one hour before or one hour after, the scheduled time; in this subparagraph, "assisting a recipient with self-administration of prescribed oral medication, eye drops, and skin ointments" has the meaning given in 7 AAC 125.030(g);

(C) the delivery or use of medication

(i) at a time other than when a medication was scheduled, if the

time was outside the acceptable range in (B) of this paragraph;

(ii) other than by the prescribed route;

(iii) other than in the prescribed dosage;

(iv) not intended for the recipient; or

(v) intended for the recipient, but given to another individual.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.160. Use of restrictive intervention. (a) A Community First Choice personal care assistants may use restrictive intervention only

(1) as a response when a recipient presents an imminent danger to the recipient's safety or to the safety of others;

(2) when other types of interventions have been tried, and documented as ineffective for safe management of the recipient's behavior that requires intervention; and

(3) if the type of intervention is safe, proportionate to the recipient's behavior, and appropriate to the recipient's chronological and developmental age, size, gender, and physical, medical, and psychological condition.

(b) The Community First Choice service provider agency shall implement written policies and procedures that address

(1) the use of restrictive intervention in regard to the recipient population served by the provider;

(2) a prohibition on the use of

(A) seclusion as a restrictive intervention;

(B) prone restraint; and

(C) chemical restraint;

(3) training in the use of restrictive intervention;

(4) documentation of each event that involves the use of restrictive intervention.

(c) The provider agency must have on file written verification that each Community First Choice personal care assistant has received training appropriate to the type of restrictive intervention the provider agency has allowed that personal care assistant to use.

(d) A personal care assistant that uses restrictive intervention shall document in the recipient's record

(1) the date and time;

(2) the duration of time each type of restrictive intervention was used;

(3) a description of the behavior that led to the use of restrictive intervention;

(4) a rationale for, and a description of, each type of restrictive intervention used;

(5) the recipient's response to each type of restrictive intervention used; and

(6) the name of each direct care worker involved in the restrictive intervention.

(e) The provider agency shall maintain a record of restrictive intervention that documents

(1) the event or circumstances that necessitated the use of restrictive intervention;

(2) the type of restrictive intervention used;

(3) the type of care provided to the recipient while a restrictive intervention is applied; and

(4) the outcome for the recipient and for the direct care worker involved in the event.

(f) The provider agency shall develop and implement a system to manage and report the use of restrictive intervention that includes

(1) a plan for documenting and tracking the use of restrictive intervention;

(2) requirements for reporting, as a critical incident under 7 AAC 127.155

(A) the misuse of restrictive intervention; and

(B) the use of restrictive intervention that resulted in the need for medical intervention;

(3) a protocol for analyzing the use of restrictive intervention each calendar quarter;

(4) a procedure for taking corrective action based on the analysis; and

(5) a process for summarizing the quarterly analyses and corrective action taken under this subsection; the summary must be submitted to the department with the provider's application for recertification under 7 AAC 127.050, or upon request.

(g) In this section,

(1) "seclusion" means the involuntary confinement of a recipient alone in a room or an area from which the recipient is physically prevented from having contact with others or leaving;

(2) “chemical restraint” means non-standard use of medication to restrict freedom of movement in order to manage or control behavior; the term does not include medication prescribed for the purpose of managing behavior by the recipient’s licensed physician, physician assistant, or advanced practice registered nurse that is qualified to practice under AS 08, or 7 AAC 105.200(c), and administered in accordance with the applicable requirements of 7AAC 125.030(d)(1). (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 127.165. Community First Choice personal care services review and appeal rights. (a) A recipient that is terminated from an agency-based personal care services program may appeal that termination through the complaints process established by the personal care services agency.

(b) If the assessment under 7 AAC 127.035 indicates that an individual is not capable of managing consumer-directed services because of a lack of cognitive capacity, or if a recipient is terminated from a consumer-directed personal care services program because the recipient lacks cognitive capacity to manage personal care services, the recipient may request a hearing under 7 AAC 49.

(c) A recipient may request a hearing under 7 AAC 49

(1) for a decision by the department to

(A) reduce or end the time allowed for a Community First Choice personal care services covered activity on the recipient's current service level authorization;

(B) deny time on a service level reauthorization for a Community First Choice personal care services activity that was included in a previous service level authorization if that activity is listed in 7 AAC 127.040;

(C) terminate the recipient's authorization to receive Community First Choice personal care services in accordance with 7 AAC 127.070; or

(D) deny Community First Choice personal care services, after review of an initial application under 7 AAC 127.030, because the recipient does not qualify for those services; or

(2) if the application is not acted upon with reasonable promptness.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC 127.190. Definitions. In 7 AAC 127.010 - 7 AAC 127.190, unless the context requires otherwise,

(1) "ADL" means activity of daily living;

(2) "agency-based program" means a program that provides personal care services to a qualified recipient that chooses not to manage, or is unable to manage those services because of cognitive capacity or a documented history of self-neglect who is unable to, or who chooses not to, take responsibility for managing those services;

(3) “assessment” means an evaluation of a recipient’s capacity to perform ADLs and IADLs over a consecutive, seven-day period, prior to and including the date of the assessment, taking into consideration other health, medical, or functional needs identified during the previous 12 months or since the recipient’s last assessment;

(4) "Community First Choice personal care service level authorization" means the authorization to provide personal care services for a recipient that was developed under 7 AAC 127.090, with any amendment under 7 AAC 127.095, and approved by the department;

(5) "consumer-directed program" means a program that provides personal care services to a recipient who takes responsibility for managing those services or whose legal representative, or the representative's designee takes, responsibility for managing those services;

(6) "CPR" means cardiopulmonary resuscitation;

(7) "cueing" means verbal guidance provided at the time an activity is to be performed that serves as a signal to a recipient to perform that activity;

(9) "IADL" means instrumental activity of daily living;

(10) "LTSS" means long term services and supports

(11) "natural supports" means

(A) individuals that, voluntarily and without payment, provide care and supports for the recipient; and

(B) the care and supports that are

(i) provided voluntarily and without pay for a recipient; and

(ii) similar to and supplemented by personal care services;

(12) "person-centered intake" means the process undertaken to help an individual understand the individual's unmet needs and to explore the resources available to meet those needs.

(13) "pre-enrollment options counseling" means the process that is undertaken by a care coordinator to assist an individual who has recently met the eligibility requirements for Home and Community-based Waiver Services or Community First Choice services to determine the kinds and level of service that will meet the individual's needs as well as non-Medicaid services available in the community.

(14) "recipient's representative" has the meaning given in 7 AAC 160.990(b);

(15) “remote community or location”

(A) means a community or location that it is not accessible by road from Anchorage or Fairbanks; or that is accessible only by crossing international boundaries; and

(B) does not include a community or location that is on a road system that connects two or more communities or locations, and the supervising registered nurse is available in one of the communities or locations;

(16) “representative’s designee” means an individual appointed by the recipient’s representative in accordance with 7 AAC 125.100(c);

(17) "restrictive intervention" means an action or procedure that limits a recipient’s movement or access to other individuals, locations, or activities;

(18) "supervision" means observing and giving direction to a recipient, as needed and at the time an activity is to be performed, to support the recipient’s independent performance of an ADL or IADL.

(Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040

AS 47.07.030

7 AAC is amended by adding a new chapter to read:

Chapter 128. Long Term Services and Supports

Targeted Case Management

7 AAC 128.010. Long term services and supports targeted case management.

(a) The department will pay for long term services and supports targeted case management services as specified in 7 AAC 145.520 if the services

(1) do not duplicate care coordination services under 7 AAC 130.240; and

(2) assist and enable an individual eligible under 7 AAC 125, 7 AAC 127, or 7 AAC 130 to gain access to necessary medical, social, educational, developmental, and related services including preparation of and submission to the department the following:

(A) a complete application;

(B) an initial support plan; payment for the support plan includes pre-enrollment counseling to discuss the range of services and supports available to the individual;

(C) an annual renewal support plan; both the initial and the renewal support plan must comply with all applicable requirements and must be accompanied by documentation of the individual's choice of service as required under 7 AAC 130.219(b)(1); and

(D) recipient-initiated contacts that may result in amendments to support plans, unless the care coordinator receives the payment for support plan amendments under 7 AAC 130.240.

(b) To be eligible to receive payment for services under this section, a provider must be

(1) certified under and comply with the requirements of 7 AAC 130.220 and 7 AAC 130.238; and

(2) enrolled as a provider of care coordination services in accordance with 7 AAC 105.210.

7 AAC 130.205. Eligibility for home and community-based waiver services.

7 AAC 130. 205 (b)(1) is amended to read:

(b) Home and Community-based Waiver Services are not available to an individual

(1) while the individual is an inpatient of a nursing facility, a hospital, or an ICF/IID [,EXCEPT FOR SCREENING UNDER 7 AAC 130.211 OR ASSESSMENT UNDER 7 AAC 130.213];

(Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204; am 7/1/2013, Register 206; am ___/___/___, Register ____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130 is amended by adding a new section to read:

7 AAC 130.206. Waiver options for the recipient category of individuals with intellectual and developmental disabilities.

(a) The applicant determined by the department to have the characteristics described in AS 47.80.900(6) may request placement on a waiting list established under AS 47.80.130(d) for the *Individualized Supports Waiver* or the *People with Intellectual and Developmental Disabilities Waiver* or both waivers. If funding for waiver services is available, the applicant that meets all eligibility requirements may be eligible for one of the following:

(1) Individualized Supports Waiver benefits up to an individual cost limit of $17,500 annually, adjusted for inflation using the CMS Home Health Agency Market Basket in the most recent quarterly publication of Global Insight's *Healthcare Cost Review* available 60 days before July 1, for the following services:

(A) chore services under 7 AAC 130.245;

(B) day habilitation under 7 AAC 130.260;

(C) residential habilitation for recipients of either in-home support habilitation under 7 AAC 130.265 (d) – (e) or supported-living habilitation under 7 AAC 130.265 (h) – (i);

(D) supported employment under 7 AAC 130.270;

(E) intensive active treatment for recipients age 21 and older under 7 AAC 130.275;

(F) respite care under 7 AAC 130.280;

(G) transportation under 7 AAC 130.290; or

(2) The Individuals with Intellectual and Developmental Disabilities Waiver benefits for all services offered in accordance with 7 AAC 130.240 – 130.305.

(b) When an applicant's name is drawn from a waiting list, the department will send to the applicant a notice to proceed letter specifying the waitlist from which their name has been drawn. If the applicant chooses to continue the process to apply for the waiver specified in the notice to proceed letter, the applicant must within 30 days of receipt of the notice to proceed letter, submit in a format provided by the department

(1) the applicant's choice to proceed to determine eligibility for waiver benefits;

(2) appointment of a care coordinator certified under 7 AAC 130.238; and

(3) a signed release of information form permitting communication between the department and the care coordinator.

(c) If an applicant does not respond to the notice to proceed letter within 30 days from receipt of the letter, the department will close the applicant's case file and remove the applicant's name from the waitlist from which it was drawn.

(d) Within 30 days of receipt of and as required by the notice to proceed letter, the care coordinator appointed by the applicant must submit to the department the following documentation in a format provided by the department:

(1) consent for an assessment using the Inventory for Client and Agency Planning (ICAP), adopted by reference in 7 AAC 160.900, and a signed release of information form for each of three named ICAP respondents or for applicants less than 36 months of age, information as specified in the notice to proceed letter;

(2) a certification of a qualifying diagnosis indicating one of the following:

(A) intellectual disability;

(B) other intellectual disability related condition;

(C) cerebral palsy;

(D) seizure disorder;

(E) autism spectrum disorder;

(3) the date of a scheduled evaluation, or documentation of an evaluation that supports a diagnosis specified in (e)(2) of this section and that was completed within the prior 12 months for individuals less than 36 months of age or within the prior 36 months for individuals 36 months of age and older.

(e) The documentation required under (d)(2) of this section must support

(1) a finding that the disability originated before the individual reached age 22, is likely to continue indefinitely, and results in substantial functional limitations to three or more of the following major life activities limited to (A) through (E) for an individual 15 years of age and under, and including (A) through (G) for an individual 16 years of age and older:

(A) self-care;

(B) understanding and use of language;

(C) learning;

(D) mobility;

(E) self-direction;

(F) capacity for independent living;

(G) economic self-sufficiency; and

(2) a diagnosis by a professional qualified to practice under AS 08 or 7 AAC 105.200 (c) or (d) made in accordance with the following:

(A) for intellectual disability,

(i) assessment with an individually-administered, standardized intelligence and adaptive skills test; and

(ii) diagnosis by a psychologist or psychological associate of a condition that meets the criteria for a diagnostic code for intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders, adopted by reference in 7 AAC 160.900;

(B) for other intellectual disability-related condition, diagnosis by a psychologist, neuropsychologist, or psychological associate of a condition that

(i) results in an impairment of general intellectual functioning and adaptive skills, and requires treatment or services similar to that required for an individual with intellectual disability; and

(ii) is other than mental illness, psychiatric impairment, or serious emotional or behavioral disturbance;

(C) for cerebral palsy, diagnosis by a physician of the condition in which an intellectual impairment need not be present;

(D) for seizure disorder, diagnosis by a physician of the condition in which an intellectual impairment need not be present; or

(E) for autism spectrum disorder, diagnosis by a neurologist, clinical psychologist, child psychiatrist, or developmental pediatrician of a condition that meets the criteria for a diagnostic code for autism spectrum disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, adopted by reference in 7 AAC 160.900.

(f) The department will conduct an assessment in accordance with 7 AAC 130.213, and make a level-of-care determination in accordance with 7 AAC 130.215(3). Following notification of the department's determination, the care coordinator shall develop and submit to the department a support plan in accordance with 7 AAC 128.010 and 7 AAC 130.217.

(g) If, based on a review of the assessment or the support plan developed under (f) of this section, the department determines that the expected costs of the services that the applicant requires exceeds the cost limit of the Individualized Supports Waiver, the applicant will be denied entrance to or continued enrollment in the Individualized Supports Waiver program.

(h) During any three year period, a recipient of Individualized Supports Waiver services may request by an amendment to the recipient's support plan up to an additional $5,000 for services and supports to address needs related to a time-limited change in the recipient's health, behavior, or functional capacity, or to the recipient's primary unpaid caregiver for a reason stated in 7 AAC 130.209 (a)(3) – (5).

7 AAC 130.207. Application for home and community-based waiver services.

7 AAC 130.207(a) is repealed and readopted to read:

(a) To apply for home and community-based waiver services under this chapter, an individual must submit a complete application for home and community-based waiver services and complete supporting documents to the department, using,

(1) for the recipient category of children with complex medical conditions, the department's Application for Alaskans Living Independently Waiver, the Adults with Physical and Developmental Disabilities Waiver, and the Children with Complex Medical Conditions Waiver form, adopted by reference in 7 AAC 160.900;

(2) for the recipient category of adults with physical and developmental disabilities, the department's Application for Alaskans Living Independently Waiver, the Adults with Physical and Developmental Disabilities Waiver, and the Children with Complex Medical Conditions Waiver form, adopted by reference in 7 AAC 160.900;

(3) for the recipient category of individuals with intellectual and developmental disabilities, the department's [INTELLECTUAL &] Developmental Disabilities Registration and Review form, adopted by reference in 7 AAC 160.900; and

(4) for the recipient category of older adults or adults with physical disabilities, the department's Application for Alaskans Living Independently Waiver, the Adults with Physical and Developmental Disabilities Waiver, and the Children with Complex Medical Conditions Waiver form, adopted by reference in 7 AAC 160.900;

(Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am ___/___/___, Register ____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045

AS 47.07.030

7 AAC 130.211(b)(1) is amended to read:

(b) **The** [IF A CARE COORDINATOR CONDUCTS THE SCREENING] care coordinator **selected by the applicant to assist with the application** shall

(1) inform the applicant regarding the care coordinator's relationship as an employee of any provider certified under 7 AAC 130.220 and of any relationship described in 7 AAC 130.240**(e)** [(f)]; and

(Eff. 7/1/2013, Register 206; am ___/___/___, Register ____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.217. Plan of care development and amendment.

7 AAC 130.217(a)(1)(A) is amended to read:

(A) the care coordinator's relationship as an employee of any provider certified under 7 AAC 130.220 and of any relationship described in 7 AAC 130.240**(e)** [(f)];

7 AAC 130.217(a)(4)(A)(ii) is amended to read:

(ii) is aware of any relationship between the care coordinator and any provider certified under 7 AAC 130.220 and of any relationship described in 7 AAC 130.240**(e)** [(f)]; and

(Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am ___/___/___, Register ____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.240 is repealed and readopted to read:

7 AAC 130.240. Care coordination services.

(a) The department will pay for care coordination services that are

(1) provided in accordance with the department's Care Coordination Conditions of Participation, adopted by reference in 7 AAC 130.217 and 7 AAC 130.218; and

(2) approved in the recipient's support plan.

(b) The department will pay a monthly care coordination service rate, established in accordance with 7 AAC 145.520, if the care coordinator

(1) for a recipient of an Individualized Supports Waiver,

(A) makes one in-person contact at least once every three months, and one telephone contact in each of the subsequent two months;

(B) ensures that at a minimum one of the in-person contacts required in (1)(A) of this section is accomplished in one of the settings where Individualized Supports Waiver services are provided;

(C) after each visit with the recipient, completes and retains as documentation of the visit a recipient contact report in accordance with the department's *Care Coordination and Long Term Services and Supports Targeted Case Management Services Conditions of Participation*, adopted by reference in 7 AAC 160.900.

(2) for a recipient of all other waivers, including the People with Intellectual and Developmental Disabilities waiver,

(A) remains in contact with the recipient or the recipient's representative in a manner and with a frequency appropriate to the needs and communication abilities of the recipient, but at a minimum makes two contacts each month with the recipient or the recipient's

representative; one of the two contacts must be an in-person visit with the recipient, unless the department waives the visit requirement under (d) of this section;

(B) monitors service delivery by meeting in person with the recipient in each service environment at least once during the plan year, unless the department waives the visit requirement under (d) of this section; and

(C) after each visit with the recipient, completes and retains as documentation of each visit a recipient contact report in accordance with the department's Care Coordination Conditions of Participation, adopted by reference in 7 AAC 160.900.

(c) The department will pay the monthly care coordination service rate beginning the first of the month that the recipient is enrolled under 7 AAC 130.219(b) and has a support plan approved in accordance with 7 AAC 130.217 and 7 AAC 130.218, for the following ongoing activities provided in accordance with (b) of this section:

(1) routine monitoring and support;

(2) monitoring quality of care;

(3) evaluating the need for specific home and community-based waiver services;

(4) reviewing the support plan and amending the support plan as needed;

(5) coordinating multiple services and providers;

(6) assisting the recipient to apply for reassessment under 7 AAC 130.213;

(7) assisting the recipient in case terminations.

(d) The department will waive the monthly in-person visit requirements for a recipient who lives in a remote community or location if the support plan documents that

(1) the projected cost of travel to visit the recipient once a month is 50 percent or more of the payment for all care coordination services for all recipients that receives those

services from the provider employing the care coordinator and that reside in the destination community or location for the 12-month period of the request;

(2) in the remote community or location,

(A) a care coordinator is not available; or

(B) each care coordinator that is available is unwilling or unable to provide services to the recipient;

(3) the care coordinator makes one in-person visit every three months; and

(4) infrequent in-person contacts will not compromise the health, safety, or welfare of the recipient.

(e) A care coordinator must disclose, to the department in a format provided by the department, any close familial relationship or close business relationship with a home and community-based waiver services provider.

(f) The department will not pay for care coordination services provided by

(1) the recipient, a member of the recipient's immediate family, the recipient's representative, an individual with a duty to support the recipient under state law, a holder of power of attorney for the recipient, the recipient's personal care assistant; or

(2) a care coordinator if the home and community-based services included in the recipient’s support plan would result in personal or financial benefit to anyone other than the recipient.

(g) The department will recoup under 7 AAC 105.260 any payment for other home and community-based waiver services provided to a recipient by a care coordinator while that care coordinator provided ongoing care coordination under this section.

(h) The care coordinator shall notify the department not later than seven days after the date of a recipient's

(1) planned admission to a hospital or to a nursing facility; and

(2) discharge from a hospital or from a nursing facility.

(i) Notwithstanding (b) of this section, the department will pay for additional support plans that have received prior authorization.

(j) In this section,

(1) "close business relationship" means

(A) a five percent or greater ownership, partnership, or equity interest in another home and community-based waiver services provider or its owner; or

(B) a five percent or greater ownership, partnership, or equity interest in any other business or commercial activity in which another home and community-based waiver services provider or its owner or administrator also has a five percent or greater ownership, partnership, or equity interest;

(2) "close familial relationship" means a relationship in which the care coordinator is

(A) the spouse, parent, sibling, or child of

(i) a home and community-based waiver services provider who is a natural person; or

(ii) an owner, administrator, or employee of a home and community-based waiver services provider agency; or

(B) spouse of the parent, sibling, or child of a natural person who is

(i) a home and community-based waiver services provider; or

(ii) an owner, administrator, or employee of a home and community-based waiver services provider agency;

(3) "owner" means a person having a five percent or greater ownership, partnership, or equity interest;

(4) "remote community or location"

(A) means a community or location that is not accessible by road from Anchorage or Fairbanks or that is accessible only by crossing international boundaries;

(B) does not include a community or location that is on a road system that connects two or more communities or locations, if the services are available in one of them.

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am ___/___/___, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.265(i)(2)(A) is amended to read:

(i) The department will pay for in-home support habilitation services under (h) of this section, subject to the following limitations:

•••

(2) when in-home support habilitation services are authorized for the recipient, the department will not make separate payment for

(A) personal care services under **7 AAC 127.090 – 7 AAC 127.140 or** 7 AAC 125.010 - 7 AAC 125.199;

•••

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214;

am ___/___/____, Register ____)

Authority: AS 47.05.010 **AS 47.07.036** AS 47.07.040

AS 47.07.030

7 AAC 130.319 is amended to read:

7 AAC 130.319. Definitions.

(15) "residential supported-living services provider" means a provider that the department has certified under 7 AAC 130.220 to provide residential supported-living services under 7 AAC 130.255**;**

(16) "support plan" means plan of care.

(Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am ___/___/___, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

Chapter 145. Medicaid Payment Rates.

7 AAC 145.500 is repealed and readopted to read:

7 AAC 145.500. Personal care services payment rates.

(a) For providing personal care services under 7 AAC 125.010 – 7 AAC 125.199 and 7 AAC 125.010 - 7 AAC 125.199, the department will pay a unit of service at the lesser of

(1) rates established in the department's *Chart of Personal Care Attendant and Waiver Services Rates*, adopted by reference in 7 AAC 160.900; those rates will be adjusted in accordance with (b) of this section; or

(2) the amount charged by the provider in accordance with 7 AAC 145.020.

(b) Each July 1, rates established in the *Chart of Personal Care Attendant and Waiver Services Rates* will be adjusted as provided in 7 AAC 145.520(g) . For state fiscal year 2018, the department will not apply the inflation adjustment described in 7 AAC 145.520(g) (1).

(c) On or after July 1, 2017, rates of payment established in the *Chart of Personal Care Attendant and Waiver Service Rates*, as adjusted under 7 AAC 145.520(g) , will be reestablished at least every four years based on the requirements of 7 AAC 145.531 - 7 AAC 145.537, and the results of provider cost surveys submitted in accordance with 7 AAC 145.533 - 7 AAC 145.537, using cost survey costs from the provider's first fiscal year beginning on or after July 1, 2014, with the cost surveys due to the department nine months after the end of the provider's fiscal year.

(d) If a provider does not submit a complete annual report in accordance with the requirements of 7 AAC 145.531 - 7 AAC 145.537 on or before the due date of the report, the provider is subject to the provisions of 7 AAC 145.520(*l*) .

7 AAC 145.520(b) is repealed and adopted to read:

(b) For care coordination services provided under 7 AAC 130.240, the department will pay a unit of service at the lesser of the

(1) amount charged by the provider to the public; or

(2) rates established in the department's *Chart of Personal Care Attendant and Waiver Services Rates*, adopted by reference in 7 AAC 160.900;

(3) the rate of payment for care coordination services provided under 7 AAC 130.240(1) and 7 AAC 130.240(2) shall be reestablished at least every four years using a modeled rate methodology that accounts for salaries, fringe benefits, administrative/general, and

caseload size; and

(4) Each July 1 that the rates of payment for care coordination services in the *Chart of Personal Care Attendant and Waiver Services Rates* are not reestablished under (4), rates established in the Chart of Personal Care Attendant and Waiver Services Rates will be adjusted as provided in 7 AAC 145.520(g). For state fiscal year 2018, the department will not apply the inflation adjustment described in 7 AAC 145.520(g) (1).

7 AAC 145 is amended by adding a new section to read:

7 AAC 145.290. Long Term Services and Supports Targeted Case Management.

(a) For Long Term Services and Supports Targeted Case Management provided under 7 AAC 128.010, the department will pay a unit of service at the lesser of the

(1) amount charged by the provider to the public; or

(2) the rate established in the department's *Chart of Long Term Services and Supports Targeted Case Management Services Rates*, adopted by reference in 7 AAC 160.900(d).

(b) On or after January 1, 2018, the rate of payment for Long Term Services and Supports Targeted Case Management monthly service shall be paid at $119.00 per unit.

(c) On or after January 1, 2018, the rate of payment for Long Term Services and Supports Targeted Case Management application services shall be paid at $90.33 per unit.

(d) On or after January 1, 2018, the rate of payment for Long Term Services and Supports Targeted Case Management targeted case management support plan development and annual renewal of support plan services shall be paid at $384.81 per unit.

(e) On or after January 1, 2018, the rates in the *Chart of Long Term Services and Supports Targeted Case Management Services Rates* shall be reestablished at least every four

years using a modeled rate methodology that accounts for salaries, fringe benefits, administrative/general, and case load size.

(f) Each July 1 that the rate of payment listed in the *Chart of Long Term Services and Supports Targeted Case Management Services Rates* is not reestablished under (e), the department shall adjust the payment rate for inflation using the CMS Home Health Agency Market Basket in the most recent quarterly publication of Global Insight's *Healthcare Cost Review* available 60 days before July 1.

Chapter 160. Medicaid Program; General Provisions.

Sec 900. Requirements adopted by reference.

7 AAC 160.900(d)(10) is amended to read:

(10) the *Chart of Personal Care Attendant and Waiver Services Rates*, dated **August 17, 2017** [APRIL 24, 2013], for providers of personal care services under 7 AAC 125.010 - 7 AAC 125.199 **and 7 AAC 127.010 –7 AAC 127.190,** and home and community-based waiver services under 7 AAC 130;

7 AAC 160.900(d)(31) is amended to read:

(31) the Application for Alaskans Living Independently Waiver**,** and Adults with Physical and Developmental Disabilities Waiver, and Children with Complex Medical Conditions Waiver, dated **October 19, 2017** [MAY 13, 2013];

7 AAC 160.900(d)(34) is amended to read:

(34) the Care Coordination **and Long Term Services and Supports Targeted Case Management** Services Conditions of Participation, dated **October 10, 2017** [MARCH 4, 2015];

7 AAC 160.900(d)(47) is repealed:

(47) repealed ____/____/____;

7 AAC 160.900(d)(55) is amended to read:

(55) the Personal Care Services **and Community First Choice Personal Care Services** Provider Conditions of Participation, dated **October 10, 2017**;

7 AAC 160.900(d) is amended by adding a new paragraph to read:

(56) the *Community First Choice Personal Care Assistance Service Level Computation*, dated December 5, 2016;

7 AAC 160.900(d) is amended by adding a new paragraph to read:

(57) the *Chart of Long Term Services and Supports Targeted Case Management Services Rates*, dated August 17, 2017.

(Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 12/1/2010, Register 196; am 1/1/2011, Register 196; am 1/15/2011, Register 197; am 2/9/2011, Register 197; am 3/1/2011, Register 197; am 10/1/2011, Register 199; am 12/1/2011, Register 200; am 1/26/2012, Register 201; am 3/8/2012, Register 201; am 4/1/2012, Register 201; add'l am 4/1/2012, Register 201; am 5/11/2012, Register 202; am 10/16/2012, Register 204; am 11/3/2012, Register 204; am

12/1/2012, Register 204; am 12/2/2012, Register 204; am 1/1/2013, Register 204; am 1/16/2013, Register 205; am 7/1/2013, Register 206; add'l am 7/1/2013, Register 206; am 11/3/2013, Register 208; am 1/1/2014, Register 208; am 2/2/2014, Register 209; am 3/19/2014, Register 209; am 3/22/2014, Register 209; am 5/18/2014, Register 210; am 2/26/2015, Register 213; am 3/15/2015, Register 213; am 7/1/2015, Register 214; am 5/1/2016, Register 218; am 6/16/2016, Register 218; am ___/___/____, Register ____; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

AS 47.05.012

7 AAC 160.990(b) is amended by adding a new paragraph to read:

(106) "Community First Choice" has the meaning given in 42 U.S.C. 1396n Sec. 1915(k).

(Eff. 2/1/2010, Register 193; am 7/7/2010, Register 195; am 1/1/2011, Register 196; am 10/1/2011, Register 199; am 4/1/2012, Register 201; am 7/1/2013, Register 206; am 5/18/2014, Register 210; am 6/16/2016, Register 218; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.055